



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JAMES WEISS MD
3100 TIMMONS LANE SUITE 250
HOUSTON TEXAS 77027

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-2918-01

MFDR Date Received

May 2, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier refuses to pay full amount due for services rendered even aftr [sic] a request for reconsideration was submitted."

Amount in Dispute: \$609.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT 95900 and 95903 are not to be billed in conjunction together. Code 95903 gives proper credit to the nerve conduction studies, which were performed. The additional value of code 95903 accounts for use of the F-wave study. Procedure code 95900 is included in the procedure code 95903, therefore the billing of these codes in conjunction results in a duplicate billing. Therefore, no additional recommendation for payment is warranted at this time"

Response Submitted by: SRS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 24, 2011	99203, 95861, 95900, 95903, 95904 and A4556	\$609.56	\$4.60

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline procedure for professional medical services provided on or after March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated April 5, 2011

- W1 – Workers Compensation State Fee Schedule Adjustment
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

Explanation of benefits dated April 21, 2011

- W4 – No additional reimbursement allowed after review of appeal/reconsideration

Issues

1. Did the requestor bill for services in conflict with NCCI edit?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT codes 99203, 95861, 95900, 95903, 95904 and A4556 rendered on March 24, 2011.
2. 28 Texas Administrative Code §134.203 states in pertinent part, “(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.”
 - NCCI edits were run to identify if the disputed charges contain edit conflicts.
 - Per CCI Guidelines, Procedure Code 95900 has a CCI conflict with Procedure Code 95903. Review of documentation to determine if a modifier is appropriate, revealed that no payment modifier was applied to CPT code 95900, therefore reimbursement cannot be recommended for CPT code 95900.
 - Per Medicare guidelines procedure code A4556 is an item or service that has no separate payment under the physician fee schedule. Reimbursement for HCPCS code A4556 is therefore not recommended.
 - CPT codes 99203, 95903, 95904, 95961 did not contain NCCI edit conflicts and will therefore be reviewed according to the applicable guidelines.
3. 28 Texas Administrative Code §134.203 states in pertinent part, “(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting... Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year...”
 - The insurance carrier issued payment for CPT codes; 99203, 95903, 95904 and 95861 rendered on March 24, 2011.
 - For every service that is assigned a value by Medicare there is a specific reimbursement amount in the workers' compensation system. The reimbursement will vary depending upon the geographic area where the service is provided. Review of box 32 of the CMS-1500 documents that the services were rendered in Houston, Texas, zip code 77027, the carrier (MAC) locality is Houston; therefore Houston is selected to determine the Medicare reimbursement for the disputed CPT codes.
 - The requestor billed CPT code 99203 in the amount of \$167.04. The insurance carrier issued payment in the amount of \$166.54. The DWC's fee guideline reimbursement is \$169.80. The requestor seeks reimbursement in the amount of \$0.50, this amount is recommended.
 - The requestor billed CPT code 95903 x 6 units in the amount of \$673.20. The insurance carrier issued payment in the amount of \$671.22. The DWC's fee guideline reimbursement is \$729.25. The requestor seeks reimbursement in the amount of \$1.98, this amount is recommended.
 - The requestor billed CPT code 95904 x 6 units in the amount of \$511.02. The insurance carrier issued payment in the amount of \$509.52. The DWC's fee guideline reimbursement is \$551.02. The requestor seeks reimbursement in the amount of \$1.50, this amount is recommended.
 - The requestor billed CPT code 95861 in the amount of \$211.60. The insurance carrier issued payment in the amount of \$210.98. The DWC's fee guideline reimbursement is \$225.71. The requestor seeks reimbursement in the amount of \$0.62, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$4.60.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$4.60 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	June 14, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.